

18 Month Pre-Visit Questionnaire

Instructions: Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.

General Health

1	Do you have concerns about your child's health?	NO	YES
2	Has your child had any problems with shots or immunizations?	NO	YES
3	Does your child receive health care from anyone besides a medical doctor (acupuncturist, chiropractor, naturopath)?	NO	YES

Review of Systems

4	Do you have any concerns about your child's hearing?	NO	YES
5	Do you have any concerns about your child's vision?	NO	YES

Feeding/Nutrition

6	Is your child still breastfeeding?	NO	YES
7	Is your child drinking formula or milk well?	YES	NO
	a. Which kind of milk or formula?		
	b. How much milk per day?		
8	Does your child eat fruits or vegetables at every meal?	YES	NO
9	Do you feed your child mostly whole grains?	YES	NO
10	Does your family eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than once or twice per week?	NO	YES
11	Does your child snack more than 2 times a day?	NO	YES
12	Do you keep away any foods that your child can choke on (raw vegetables, nuts, hot dogs, popcorn)?	YES	NO
13	Does your child drink from a bottle?	NO	YES
14	Does your child drink juice or other sweetened drinks?	NO	YES
15	Do you give your child any vitamins or supplements?	NO	YES
16	Are you worried about your child's weight?	NO	YES

Oral Health

17 Are cavities a problem for you or anyone in your family?	NO	YES
18 Are you using a soft toothbrush with fluoridated toothpaste to clean your child's teeth 2 times per day?	YES	NO
19 Do you have a dentist for your child?	YES	NO
20 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO
21 Does your child only drink milk at meals?	YES	NO

Elimination

22 Does your child have any problems with bowel movements (pooping)?	NO	YES
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Activity / Exercise / Screen Time

23 Does your child have screen time (smartphone, tablet, TV)?	NO	YES
24 Do you play with your child every day?	YES	NO
25 Do you read to your child every day?	YES	NO

Sleep

26 Does your child sleep through the night?	YES	NO
27 Do you have a bedtime routine?	YES	NO
28 Does your child fall asleep on his own, in his/her own bed?	YES	NO

Social Stressors

29 Do you feel you receive the support you need?	YES	NO	
30 Have there been any major changes or stresses in your family recently?	NO	YES	
31 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
32 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES

Behavior

33 Do you have any questions about your child's behavior or how to discipline your child?	NO	YES
34 Do you praise your child when he/she is behaving well?	YES	NO

Lead

35 Is your child regularly in a house built before 1978?	NO	YES
a. Is there any peeling or chipping paint or are you remodeling?	NO	YES
36 Does your child have a brother, sister, or playmate who ever had lead poisoning?	NO	YES

Safety

37 Is the crib mattress at the lowest position?	YES	NO	
38 Does anyone smoke or vape around your child?	NO	YES	
39 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
40 Do you keep plastic bags and latex balloons away from your child?	YES	NO	
41 Does your child ride in a rear-facing safety seat, in the back seat?	YES	NO	
42 Do you keep your child away from the stove?	YES	NO	
43 If there is a swimming pool, pond or lake near your home, is it secured so that your child cannot access it?	N/A	YES	NO
44 Do you have a fire escape plan?	YES	NO	
45 Do you keep furniture away from windows or use window guards?	YES	NO	
46 Do you have a gate on your stairs?	YES	NO	
47 Do you have the number for Poison Control?	YES	NO	



18 Month Questionnaire

17 months 0 days
through 18 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☒ Try each activity with your baby before marking a response.
- ☒ Make completing this questionnaire a game that is fun for you and your child.
- ☒ Make sure your child is rested and fed.
- ☒ Please return this questionnaire by _____.

Notes:

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. When your child wants something, does she tell you by <i>pointing</i> to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. When you ask your child to, does he go into another room to find a familiar toy or object? (You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket.")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (Mark "yes" even if her words are difficult to understand.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Without your showing him, does your child <i>point</i> to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" (He needs to identify only one picture correctly.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?") Please give an example of your child's word combinations:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

COMMUNICATION TOTAL —

GROSS MOTOR

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 1. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your child move around by walking, rather than by crawling on her hands and knees? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Does your child walk well and seldom fall? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Does your child climb on an object such as a chair to reach something he wants (for example, to get a toy on a counter or to "help" you in the kitchen)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? (If your child already kicks a ball, mark "yes" for this item.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |



GROSS MOTOR TOTAL

FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 1. Does your child throw a small ball with a forward arm motion? (If he simply drops the ball, mark "not yet" for this item.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your child stack a small block or toy on top of another one? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Does your child stack three small blocks or toys on top of each other by himself? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |



FINE MOTOR TOTAL

PROBLEM SOLVING

1. Does your child drop several small toys, one after another, into a container like a bowl or box? (You may show him how to do it.)

YES ☐ SOMETIMES ☐ NOT YET ☐ _____

2. After you have shown your child how, does she try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool?



☐ ☐ ☐ _____

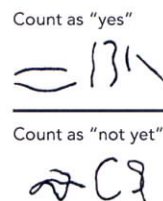
3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? (You may show him how.) (You can use a soda-pop bottle or a baby bottle.)

☐ ☐ ☐ _____

4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?

☐ ☐ ☐ _____

5. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in any direction? (Mark "not yet" if your child scribbles back and forth.)



☐ ☐ ☐ _____

6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? (Do not show him how.)

☐ ☐ ☐ _____ *

PROBLEM SOLVING TOTAL _____

*If Problem Solving Item 6 is marked "yes" or "sometimes," mark Problem Solving Item 3 "yes."

PERSONAL-SOCIAL

1. While looking at herself in the mirror, does your child offer a toy to her own image?

YES ☐ SOMETIMES ☐ NOT YET ☐ _____

2. Does your child play with a doll or stuffed animal by hugging it?

☐ ☐ ☐ _____

3. Does your child get your attention or try to show you something by pulling on your hand or clothes?

☐ ☐ ☐ _____

4. Does your child come to you when he needs help, such as with winding up a toy or unscrewing a lid from a jar?

☐ ☐ ☐ _____

5. Does your child drink from a cup or glass, putting it down again with little spilling?

☐ ☐ ☐ _____

6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?

☐ ☐ ☐ _____

PERSONAL-SOCIAL TOTAL _____

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain:

☐ YES

☐ NO

2. Do you think your child talks like other toddlers his age? If no, explain:

☐ YES

☐ NO

3. Can you understand most of what your child says? If no, explain:

☐ YES

☐ NO

4. Do you think your child walks, runs, and climbs like other toddlers her age?
If no, explain:

☐ YES

☐ NO

5. Does either parent have a family history of childhood deafness or hearing
impairment? If yes, explain:

☐ YES

☐ NO

6. Do you have concerns about your child's vision? If yes, explain:

☐ YES

☐ NO

OVERALL (continued)

7. Has your child had any medical problems in the last several months? If yes, explain:

☐ YES☐ NO

8. Do you have any concerns about your child's behavior? If yes, explain:

☐ YES☐ NO

9. Does anything about your child worry you? If yes, explain:

☐ YES☐ NO



18 Month ASQ-3 Information Summary

17 months 0 days through
18 months 30 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____ Was age adjusted for prematurity
when selecting questionnaire? ☐ Yes ☐ No

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	13.06		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gross Motor	37.38		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine Motor	34.32		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem Solving	25.74		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal-Social	27.19		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- | | | | | | |
|--|-----|---------------|--|------------|----|
| 1. Hears well?
Comments: | Yes | NO | 6. Concerns about vision?
Comments: | YES | No |
| 2. Talks like other toddlers his age?
Comments: | Yes | NO | 7. Any medical problems?
Comments: | YES | No |
| 3. Understand most of what your child says?
Comments: | Yes | NO | 8. Concerns about behavior?
Comments: | YES | No |
| 4. Walks, runs, and climbs like other toddlers?
Comments: | Yes | NO | 9. Other concerns?
Comments: | YES | No |
| 5. Family history of hearing impairment?
Comments: | | YES No | | | |

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the ☐ area, it is above the cutoff, and the child's development appears to be on schedule.

If the child's total score is in the ☐ area, it is close to the cutoff. Provide learning activities and monitor.

If the child's total score is in the ☐ area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

- _____ Provide activities and rescreen in _____ months.
- _____ Share results with primary health care provider.
- _____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- _____ Refer to primary health care provider or other community agency (specify reason): _____
- _____ Refer to early intervention/early childhood special education.
- _____ No further action taken at this time
- _____ Other (specify): _____

5. **OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						



Child's name _____
Age _____

Date _____
Relationship to child _____

M-CHAT-R™ (Modified Checklist for Autism in Toddlers Revised)

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (FOR EXAMPLE , if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (FOR EXAMPLE , pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (FOR EXAMPLE , furniture, playground equipment, or stairs)	Yes	No
5. Does your child make <u>unusual</u> finger movements near his or her eyes? (FOR EXAMPLE , does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (FOR EXAMPLE , pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (FOR EXAMPLE , pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (FOR EXAMPLE , does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE , showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (FOR EXAMPLE , does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (FOR EXAMPLE , does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (FOR EXAMPLE , wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (FOR EXAMPLE , does your child look at you for praise, or say “look” or “watch me”?)	Yes	No
18. Does your child understand when you tell him or her to do something? (FOR EXAMPLE , if you don't point, can your child understand “put the book on the chair” or “bring me the blanket”?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (FOR EXAMPLE , if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (FOR EXAMPLE , being swung or bounced on your knee)	Yes	No